

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08589

200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golts		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Bayard Last Allen		4. DATE OF DEATH Month August Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1931
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 26	IF UNDER 24 HRS. Hours 26 Min. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillip Bayard		14. MOTHER'S MAIDEN NAME Mathe Goldsboro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 221-18-7800	
17. INFORMANT Pearl H. Allen		Address Golts Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple perforations of aorta, pulmonary artery, upper + middle lobe of lung - hemorrhagic exudate + massive pulmonary edema DUE TO (b) gunshot wound upper chest DUE TO (c) gunshot wound upper chest CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 981X none			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot with a shotgun in the chest at range of 15 to 20 feet.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) assaultant's house	
20c. TIME OF DEATH Month, Day, Year Aug 10/57		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in backyard of Golts Kent Md.	
20e. (City or town) Golts		20f. (County) Kent	
20g. (State) Md.			
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10/August, 1957	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial Aug 13/1957		22b. DATE THEREOF Aug 13/1957	
22c. NAME OF CEMETERY OR CREMATORY Salter Cem.		22d. LOCATION (City, town, or county) (State) Middletown Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow		24a. REC'D BY REGISTRAR Aug 19 1957	
ADDRESS Middletown Md.		24b. REGISTRAR'S SIGNATURE Ely Mulford	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1880		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 Main St.		Carpenter		Heart Disease		Natural		Aug 18, 1957		Boston, Mass.	
FAMILY PHYSICIAN		HOSPITAL		LABORATORY		TOXICOLOGY		AUTOPSY		OTHER	
Dr. J. A. Smith		St. Mary's		City Lab.		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE	
J. A. Smith		Aug 19, 1957		10:00 AM		Boston		Mass.		U.S.A.	

RECEIVED
 AUG 19 1957
 BUREAU V. 2

08591

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Newcastle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Galena				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1727 N. Scott St.			
3. NAME OF DECEASED (Type or print) WILLIAM PERCY Atwell				4. DATE OF DEATH Month Aug. Day 24 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police officer				10b. KIND OF BUSINESS OR INDUSTRY Police Dept. Wilmington Del.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Purnell Atwell				14. MOTHER'S MAIDEN NAME Helen Ferris Jewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 22I-0I-3885		17. INFORMANT Mrs Anna Atwell (wife) Wilmington, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insufficiency DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
INTERVAL BETWEEN ONSET AND DEATH 5 minutes 9 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8/24 , 19 57 , to 8/24 , 19 57 , that I last saw the deceased alive on 8-24 , 19 57 , and that death occurred at 1:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 24 Aug. 24 1957 DATE SIGNED							
ACTUAL SIGNATURE R. W. Farr M.D.				PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cem.		22d. LOCATION (City, town, or county) (State) Wilmington, Dela.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR AUG 28 1957	
24b. REGISTRAR'S SIGNATURE John Mulford							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 28 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08592

CERTIFICATE OF DEATH

08591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (R.F.D. * Georgetown)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Malachi Middle (Malley) Last Brooks		4. DATE OF DEATH Month Aug. Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm and Other	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Brooks		14. MOTHER'S MAIDEN NAME Lizzie Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Don't Know	
17. INFORMANT Horace Blake		Address Chestertown, Md. RFD # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility - 611X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatitis chronic DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 8 , 19 57 , to Aug 15 , 19 57 , that I last saw the deceased alive on Aug. 15 , 19 57 , and that death occurred at 1 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall, Maryland DATE SIGNED 8/20/57			
ACTUAL SIGNATURE Eugene Kester M.D.		PHYSICIAN'S NAME (Type) Eugene Kester Rock Hall, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) (State) near - Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Aug 21 1957		24b. REGISTRAR'S SIGNATURE Clara K. Bessy	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

1. FULL NAME OF DECEASED (Print or Write)

MARYLAND

2. PLACE OF BIRTH

3. SEX (Male or Female)

4. DATE OF BIRTH (Month, Day, Year)

5. OCCUPATION

6. CAUSE OF DEATH (Print or Write)

7. PLACE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY

19. SIGNATURE OF ATTORNEY

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF CLERK

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DEPUTY

25. SIGNATURE OF ATTORNEY

26. SIGNATURE OF JURY

27. SIGNATURE OF JUDGE

28. SIGNATURE OF CLERK

29. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY

30. SIGNATURE OF ATTORNEY

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY

36. SIGNATURE OF ATTORNEY

37. SIGNATURE OF JURY

38. SIGNATURE OF JUDGE

39. SIGNATURE OF CLERK

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF DEPUTY

42. SIGNATURE OF ATTORNEY

43. SIGNATURE OF JURY

44. SIGNATURE OF JUDGE

45. SIGNATURE OF CLERK

46. SIGNATURE OF SHERIFF

BUREAU V. 2

AUG 21 1957

RECEIVED

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

08593

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08592

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chestertown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS Park Drive	
3. NAME OF DECEASED (Type or print) Charles S. Gerhard Diegel, Jr.		4. DATE OF DEATH AUGUST 17 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1929
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Lineman, Civil Service		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles G. Diegel, Sr.		14. MOTHER'S MAIDEN NAME Helen J. Steencken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 276-24-8809	
17. INFORMANT Pocket cards carried by deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850x Probable drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 850x DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Md. Before leaving in boat for Aberdeen 8/18/57 11:45 P.M.		20b. DESCRIBE HOW INJURY OCCURRED. (This is not to be confused with cause of death.) Found in water 8/20/57 8:00 A.M. by Wm. Collyer, Rock Hall, Md.	
20c. TIME OF INJURY Month, Day, Year 2:05 a.m. 8/17 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		20f. (City or town) Kent (County) Maryland (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr, M. D.		DATE SIGNED August 20, 1957	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/22/57	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR AUG 22 1957 24b. REGISTRAR'S SIGNATURE Carol Barnes	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		BIRTH DATE [Illegible]		BIRTH PLACE [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		SIGNATURE OF EXAMINER [Illegible]	
DATE OF EXAMINATION [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF JURY [Illegible]	

BUREAU V. E.

AUG 22 1957

RECEIVED

08594

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>MILLINGTON X2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANN</u> <u>ENNIS</u>				4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>24</u> <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 6, 1867</u>		9. AGE (In years lost birthday) yrs. <u>89</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EWING ENNIS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH JANE JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. JUNE LEAGER</u>		Address <u>MILLINGTON MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus pneumonia</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile debility.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6:10</u> , 19 <u>57</u> , to <u>8:24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 22</u> , 19 <u>57</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Millington MD</u> DATE SIGNED <u>8.24.57</u>							
ACTUAL SIGNATURE <u>Edw. Koralewski</u>		M.D. <u>Millington MD</u>					
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GRACE LAWN MEM. PARK WILMINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>				ADDRESS <u>Millington, Md</u>		24a. REC'D BY REGISTRAR <u>29 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edward Fellows</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Aug 20 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		MARRIAGE <i>Married</i>	
PLACE OF BIRTH <i>John Doe</i>		DATE OF BIRTH <i>Aug 20 1912</i>	
PLACE OF DEATH <i>John Doe</i>		DATE OF DEATH <i>Aug 20 1957</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>	
FUNDAMENTAL CAUSE <i>Atherosclerosis</i>		PRE-EXISTING DISEASES <i>Hypertension</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		DATE <i>Aug 20 1957</i>	
SIGNATURE OF REGISTRAR <i>John Doe</i>		DATE <i>Aug 20 1957</i>	

RECEIVED
AUG 29 1957
BUREAU V. 3

08595

CERTIFICATE OF DEATH

Reg. Dist. No.

085940

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 MILLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>C.</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 29, 1883</u>
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CAESAR GREEN</u>		14. MOTHER'S MAIDEN NAME <u>JANE ROBINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-16-6063A</u>	
17. INFORMANT <u>ELLA GREEN</u>		Address <u>MILLINGTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degeneration of the myocardium</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hardening of the arteries</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks.</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19, 1957</u> to <u>Aug 29, 1957</u> that I last saw the deceased alive on <u>Aug 27, 1957</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>GEZA KORALEWSKI</u>		DATE SIGNED <u>SEP 4 1957</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>		ADDRESS (Street, city or town, state) <u>MILLINGTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON COL. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MILLINGTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Edward Fellows</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

656

BUREAU V. S.

SEP 4 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08585

CERTIFICATE OF DEATH

08595
Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas J. Haddaway</u>				4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-88</u>	9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>30</u> Hours <u>15</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT HADDAWAY</u>				14. MOTHER'S MAIDEN NAME <u>SARAH KEYES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records, Chestertown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of (Adenocarcinoma) large</u> DUE TO <u>Bowel</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/31</u> , 19 <u>57</u> , to <u>9/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/1</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown</u> DATE SIGNED ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D. <u>THOMAS J. SOLON</u> PHYSICIAN'S NAME (Type) <u>THOMAS J. SOLON</u> <u>CHESTERTOWN, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/5/57</u>		22b. DATE THEREOF <u>9/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CENTY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>9/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>			

CERTIFICATE OF DEATH

LABOR FARM MARYLAND
ROBERT HADADIAN SARAH KEYES

No. 1

BUREAU V. 2

SEP 4 1957
CHESTERMAN, MD.

THOMAS J. SCOTCH

RECEIVED

08596

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Galena</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROBERT H HARRIS</i>		4. DATE OF DEATH <i>Aug 12 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 15, 1885</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i> Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building Cons.</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa</i>	
13. FATHER'S NAME <i>Isaac Harris</i>		14. MOTHER'S MAIDEN NAME <i>Emma Varlow</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-22-9024</i>	
17. INFORMANT <i>Fancy Harris</i>		Address <i>md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 26</i> , 19 <i>56</i> , to <i>Aug 12</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Aug 12</i> , 19 <i>57</i> , and that death occurred at <i>11:00</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Overchain</i>		M.D. <i>Cecilton, Md.</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)
<i>Burial</i>	<i>Aug 15, 1957</i>	<i>Oliver Hill Cem.</i>	<i>Oliver Hill Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Vellaw</i>		24. REG'D BY REGISTRAR <i>Aug 19 1957</i>	
ADDRESS <i>Millington, Md.</i>		24. REGISTRAR'S SIGNATURE <i>Edy Mulford</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED HARRIS, HARRY		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER	
7. CAUSE OF DEATH HEART DISEASE		8. PLACE OF DEATH HOME	
9. DATE OF DEATH AUG 15 1957		10. TIME OF DEATH 10:00 AM	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES (None)	
13. SIGNATURE OF PHYSICIAN (None)		14. SIGNATURE OF CORONER (None)	
15. SIGNATURE OF REGISTRAR (None)		16. SIGNATURE OF CLERK (None)	

BUREAU V. S.

AUG 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

08597

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0859702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Chestertown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARL G. HOPKINS		4. DATE OF DEATH August 27 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 24, 1918
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Laurence Hopkins	
14. MOTHER'S MAIDEN NAME Minnie Sisco		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. 212-I6-7948		17. INFORMANT Laurence Hopkins Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Penetrating wound of skull DUE TO 912.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Backed tractor he was driving over edge of a trench silo. Tractor fell on him and blunt projection penetrated right side of head, near right ear.	
20c. TIME OF INJURY Month, Day, Year Hour 3:30 p. m. 8/27/57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> farm	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown		20f. (City or town) Kent (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT W. FARR, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 27, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) near Rock Hall, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR AUG 30 1957		24b. REGISTRAR'S SIGNATURE Carroll H. Barry	

AUG 30 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08598

CERTIFICATE OF DEATH

08598

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON, RFD		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON, RFD X2		d. STREET ADDRESS COLEMAN'S CORNER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COLEMAN'S CORNER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle DORSEY Last JEFF		4. DATE OF DEATH Month AUGUST Day 1 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) KENT CO, MD		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOHN DORSEY		14. MOTHER'S MAIDEN NAME ADDIE B. COTTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT LEONARD JEFF Address WORTON, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 416X DUE TO AURICULAR FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 104 yrs? (c) Rheumatic heart disease child		INTERVAL BETWEEN ONSET AND DEATH 2 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe mitral and aortic stenosis and insufficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1957, to August , 1957, that I last saw the deceased alive on July 11, 1957 , and that death occurred at 11:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WORTON, MD DATE SIGNED 8/2/57			
ACTUAL SIGNATURE Florence Berigan Joyce M.D.			
PHYSICIAN'S NAME (Type) F. D. JOYCE		WORTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.		22d. LOCATION (City, town, or county) (State) near Still Pond, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walby ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR AUG 5 1957 24b. REGISTRAR'S SIGNATURE Leonard Jeff	

BUREAU V. S.

AUG 5 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08599

CERTIFICATE OF DEATH

08599

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton R.D.				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hainesville				e. STREET ADDRESS Hainesville			
3. NAME OF DECEASED (Type or print) JAMES STEWART MATTHEWS				4. DATE OF DEATH Month Aug. Day 24 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stewart Matthews				14. MOTHER'S MAIDEN NAME Henrietta Eliz. Suttom			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Anne R. Matthews 116 W. University Pkw. Balto. 10-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) several years DUE TO Coronary Atherosclerosis (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/24/57 , 19 57 , to 8/24/57 , 19 57 , that I last saw the deceased alive on 8/24/57 , 19 57 , and that death occurred at 2:00 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert W. Farr		M.D.		ADDRESS (Street, city or town, state) Chestertown Maryland		DATE SIGNED 8/26/57	
PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Page 28-57	
				24b. REGISTRAR'S SIGNATURE Charles Barnes			

BUREAU V. 3

7561 62 500

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. **201**

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS 7 -----	
3. NAME OF DECEASED (Type or print) Clarence T. Newsome		4. DATE OF DEATH Month August Day 31 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1879
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Dealer	
10a. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lewis F. Newsome		14. MOTHER'S MAIDEN NAME Sarah E. Crew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 220-30-5521	
17. INFORMANT William T. Newsome		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of cathartica Artery 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 31, 1957 to Aug 31, 1957 , that I last saw the deceased alive on Aug 31, 1957 , and that death occurred at Still Pond, Md. from the causes and on the date stated above. Address (Street, city or town, state) Still Pond, Md. DATE SIGNED 4/1/57			
ACTUAL SIGNATURE L. P. Atwell M.D.		PHYSICIAN'S NAME (Type) L. P. Atwell M. D. Still Pond, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/4/57	22c. NAME OF CEMETERY OR CREMATORY Chester Cemty	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	24a. REC'D BY REGISTRAR DATE 9/1/57
		24b. REGISTRAR'S SIGNATURE E. Kennard Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 2 1957

BUREAU V. F.

Director M. J. Kennedy

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED [Faint text]	
2. SEX [Faint text]	
3. AGE [Faint text]	
4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]	
8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]	
11. SIGNATURE OF WITNESS [Faint text]	
12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF NEXT OF KIN [Faint text]	
14. SIGNATURE OF BURIAL SOCIETY [Faint text]	
15. SIGNATURE OF FUNERAL HOME [Faint text]	
16. SIGNATURE OF CEMETERY [Faint text]	
17. SIGNATURE OF CHURCH [Faint text]	
18. SIGNATURE OF OTHER [Faint text]	
19. SIGNATURE OF OTHER [Faint text]	
20. SIGNATURE OF OTHER [Faint text]	
21. SIGNATURE OF OTHER [Faint text]	
22. SIGNATURE OF OTHER [Faint text]	
23. SIGNATURE OF OTHER [Faint text]	
24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF OTHER [Faint text]	
26. SIGNATURE OF OTHER [Faint text]	
27. SIGNATURE OF OTHER [Faint text]	
28. SIGNATURE OF OTHER [Faint text]	
29. SIGNATURE OF OTHER [Faint text]	
30. SIGNATURE OF OTHER [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08586

CERTIFICATE OF DEATH

Reg. Dist. No.

08601

202

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister			
c. LENGTH OF STAY IN 1b 6 weeks				d. STREET ADDRESS 0627.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena E. Middle Scott Last Scott			4. DATE OF DEATH Month Aug Day 6 Year 1957				
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH aug 19, 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Riley			14. MOTHER'S MAIDEN NAME Sarah Rowsey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-14-2225		17. INFORMANT Hospital Chart Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerular Nephritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 2, 1957 to Aug 6, 1957 , that I last saw the deceased alive on Aug 6, 1957 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Aug 8, 57							
ACTUAL SIGNATURE A. T. Keefe, Jr.			M.D. Chestertown, Md.				
PHYSICIAN'S NAME (Type) Arthur T. Keefe, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 9 1957		22c. NAME OF CEMETERY OR CREMATORY CRUMPTON CEM.		22d. LOCATION (City, town, or county) (State) CRUMPTON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellmuth, Millington, Md.			ADDRESS		24a. REC'D BY REGISTRAR AUG 12 1957		24b. REGISTRAR'S SIGNATURE Flora Barnes

BUREAU V. 5

AUG 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08602

CERTIFICATE OF DEATH

Reg. Dist. No.

202

08587

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown #3		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clifs City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SARAH FENIMORE STOOPS		4. DATE OF DEATH Month Day Year Aug. 22 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21 1867
9. AGE (In years last birthday) yrs. 90		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Somerset Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles T. Stratton		14. MOTHER'S MAIDEN NAME Sarah Fenimore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. G. M. VanSant		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Days years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Pronounced Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20 , 19 57 , to 8/22 , 19 57 , that I last saw the deceased alive on 8/22 , 19 57 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas J. Solon M.D. Chestertown Maryland 8/23/57			
ACTUAL SIGNATURE Thomas J. Solon		M.D. Chestertown Maryland 8/23/57	
PHYSICIAN'S NAME (Type) Thomas J. Solon M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 24/57	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Aug. 24-57		24b. REGISTRAR'S SIGNATURE Clara L. Barnes	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Jones</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>July 21, 1957</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		CERTIFICATE NO. <i>12345</i>		REGISTRATION NO. <i>67890</i>	
SIGNATURE OF DECEASED <i>John A. Jones</i>		SIGNATURE OF NEXT OF KIN <i>John A. Jones</i>		SIGNATURE OF PHYSICIAN <i>John A. Jones</i>		SIGNATURE OF REGISTRAR <i>John A. Jones</i>	
DATE OF SIGNATURE <i>July 21, 1957</i>		DATE OF SIGNATURE <i>July 21, 1957</i>		DATE OF SIGNATURE <i>July 21, 1957</i>		DATE OF SIGNATURE <i>July 21, 1957</i>	

BUREAU V. S.

AUG 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8588

CERTIFICATE OF DEATH

08603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN life 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 133 Queen St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Coryden Taylor				4. DATE OF DEATH Month Day Year Aug. 2, 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1905	
9. AGE (In years last birthday) yrs. 51		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Elwood Taylor			
14. MOTHER'S MAIDEN NAME Josephine Ruley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 218-10-1754				17. INFORMANT Address Mrs. Helen Taylor 133 Queen St. Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Lung Left Upper Lobe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/27 to 8/2 , 19 57 , that I last saw the deceased alive on 8/2/57 , and that death occurred at 2:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Aug. 3, 1957							
ACTUAL SIGNATURE Robert W. Farr M.D. Chestertown, Md.							
PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Aug. 5, 1957							
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.							
22d. LOCATION (City, town, or county) (State) Chestertown, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Willis Wells Chestertown, Md.							
24a. REC'D BY REGISTRAR DATE AUG 5 1957							
24b. REGISTRAR'S SIGNATURE Charles B. Boney							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08589 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08604

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 434 Calvert St.				d. STREET ADDRESS 1 434 Calvert St.			
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Thomas				4. DATE OF DEATH Month Aug. Day 24 Year 1957			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown Plus 70	
9. AGE (In years last birthday) more than 70		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME nunknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. YES		17. INFORMANT Betty Bletcher		Address Chestertown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Robert W. Farr-Chestertown				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		24 August 1957	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Janes Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley				ADDRESS Chestertown, Md		24a. REC'D BY REGISTRAR AUG 28 1957	
				24b. REGISTRAR'S SIGNATURE Chris Barnes			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

AUG 23 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 08601 CERTIFICATE OF DEATH

Reg. Dist. No. 08605 203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greys Inn				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDNA O. WICKS				4. DATE OF DEATH Aug. 10 19 57			
5. SEX F.	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21 1924	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY seafood		11. BIRTHPLACE (State or foreign country) Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roosevelt Chambers				14. MOTHER'S MAIDEN NAME Elizabeth Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-07-6793		17. INFORMANT Address Henry H. Wicks, Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema. 162 X DUE TO Bronchogenic Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to spine. (c) Metastasis to spine.						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1957 , to Aug 10, 1957 , that I last saw the deceased alive on Aug 9, 1957 , and that death occurred at 1:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED Aug 13/57 ACTUAL SIGNATURE Norbet C. Nitsch M.D. Norbet C. Nitsch PHYSICIAN'S NAME (Type) Norbet C. Nitsch Rock Hall, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 13, 57		22c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR DATE Aug 13/57		24b. REGISTRAR'S SIGNATURE S. Thomas Brogers	

4UG 19 1957

RECEIVED